ک DELTA DENTA		ENROLLMENT/CHANGE FORM – CA DUAL CHOICE Enrollment and Billing Department										Group No.	71691 03001 Effective Hire						
deltadentalins.com	Dom Select a Plan: P.O. Box 429086 San Francisco, CA 94142-9086 P.O. Box 429086 San Francisco, CA 94142-9086 ACTIVE DeltaCare® USA ¹ P.O. Box 1803 Alpharetta, GA 30023							Date / Date / /											
VERY IMPORTANT - Please Print Legibly														Pay	/ Code Benefit Package				
Enrollee/Change Information									Change Dental Plan*				Enrollee Classification						
New Enrollment Add/Delete Dependent Marital Status Change *Enrollees can change plans or	 Address Change Terminate Enrollee Covera Change Dental Plans* 	age	SSN/Enrol previous II	received	I I I	Fee-For-Service – Cancel DeltaCare USA – Cancel					D Part-Tir	 Full-Time Hourly Certified Part-Time Salaried Classified Retired Member/Other 							
			-	-	Information									COBRA	(if applicable)				
Social Security Number	Enrollee ID Number (if appli				Date of Birth		G on-binary	ender 🔲 Mal	e 🗖	Female	Single	rital Status D Married Middle Initial							
Mailing Address (Street) City State Zip Code Email Address (internal use only) Phone Number - Phone Type Cell □ Work □ Home										Widowed/Surviving Dependent** Dependent Child No Longer Eligible**									
Network [Facility Name (DeltaCare USA only]) Network [Network Facility Number (DeltaCare USA only])											Indicate qu	ualifying date	/						
Name of Other Dental Carrier Policy Holder Name (first/last)							Date of Bir					Pate of Birth			ling under his/her social security ntly enrolled under must be				
Effective Date Policy Holder Street Address of Other Policy										State	Zip Code		provided		,				
Dependent Information																			
	ependent First Name ne only if different from enrollee)	Add / Teri	Add / Term Social Security Number					1	Non hinary/		Student / Disabled***		Name of Sc (overage stude		Network Facility Number [‡] (DeltaCare USA only)				
Spouse/Partner			1			/	/												
Dependent						/	/												
Dependent				+															
Dependent Please attach a separate sheet for	additional dependent information					*** A dditi(status [‡] Maximur	n of three fac	ilities per family				
 I authorize any pay only be made if I example I decline coverage 	roll deduction that may be r perience a qualifying family	required to v status cha	wards the dange, in whi	cost of t ich case	his coverage. I c the change mus	certify th st be coi	nat the abo nsistent w	ove in ith th	Iform	ation is	true and d	correct to the l nerwise be pro	pest of my know vided by the gr	wledge. I ur oup contra	derstand that changes can				
¹ DeltaCare USA is our prepai they receive treatment.	d plan that features set cop	ayments, n	no annual de	eductibl	es and no maxir	nums fo	r covered	bene	fits. E	Inrollee	s must sel	ect a primary o	are dentist in t	he DeltaCaı	re USA network from whom				

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. You may also be able to receive this document in Spanish or Chinese. For free help, please call Delta Dental:

Delta Dental Premier® and Delta Dental PPO™: 1-800-765-6003 DeltaCare® USA: 1-800-422-4234

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重要通知:您能讀這份文件嗎?如有問題,我們可請他人協助您。您也能取得這份文件的西班牙文或中文譯本。如需免費協助,請電 Delta Dental。

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